

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32878**

FILED NOV 14 1955
BIRTH NO. **64120-55** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1000**

1. PLACE OF DEATH a. COUNTY Green		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Green	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hos.		e. STREET ADDRESS (If rural, give location) 2437 N. Delaware	
3. NAME OF DECEASED a. (First) Terry b. (Middle) Wayne c. (Last) Smith			4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Nov. 4, 1955
9. AGE (In years last birthday) — Months — Days 4		IF UNDER 1 YEAR Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Earl Smith	
13b. MOTHER'S MAIDEN NAME Nancy Jackson		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Earl Smith, 2437 N. Del. Springfield
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subtentorial intracranial hemorrhage ANTECEDENT CAUSES DUE TO (b) Trauma at birth DUE TO (c) 76'00 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 3 days		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 11-4 , 1955, to 11-7 , 1955, that I last saw the deceased alive on 11-7 , 1955, and that death occurred at 1:00pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) David D. Thompson M.D.		23b. ADDRESS Springfield 1630 Jefferson	23c. DATE SIGNED 11-8-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 8, 55	24c. NAME OF CEMETERY OR CREMATORY Sparta Cemetery	24d. LOCATION (City, town, or county) (State) Christian, Mo.
DATE REC'D BY LOCAL REG. 11-8-55	REGISTRAR'S SIGNATURE Fritz Williamson	25. FUNERAL DIRECTOR'S SIGNATURE T. B. Chaffin ADDRESS Ozark Mo.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *T. B. Chaffin*.....

Licensed Embalmer No. *219*

P. O. Address *Ozark*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.